TUBERCULOSIS CONTROL

Discharge of a Suspect or Confirmed Tuberculosis Patient

As of January 1, 1994, State Health and Safety Codes mandate that patients suspect for or confirmed with TB may not be discharged or transferred without **prior** Health Department approval, regardless of site of disease, level of infectiousness or diagnosis prior to admission.

To facilitate timely and appropriate discharge, the provider should notify the Health Department 1-2 days prior to anticipated discharge to review the discharge criteria.

Health Department Response Plan

Weekday Discharge--Non-Holiday 8:00 a.m. - 5:00 p.m.
Upon our receipt of the discharge plan, which may be sent by FAX 692-5516 or phone 692-8610, the TB Control staff will provide a response within 24 hours, as state law permits.

The TB Control staff will review the plan and notify provider of approval or will inform provider of additional information/action that is needed prior to discharge to obtain approval.

If a home evaluation is needed to determine if the environment is suitable for discharge, the TB Control staff will make a home visit within 3 working days of notification.

If the patient is homeless or there is concern for non-compliance, TB Control staff will interview the patient **prior to discharge**. This interview will take place within one working day of notification to TB Control.

Holiday and Weekend Discharge 8:00 a.m - 5:00 p.m.
The provider may page TB Control staff on pager 526-1878. Response time will usually be within one hour. The process mentioned above will be followed. If the discharge cannot be approved, the patient **MUST** be held until the next business day for appropriate arrangements to be made.

(Note: Use of form on reverse side for discharge care planning only. To fulfill state requirements for disease reporting, TB Suspect Case Form must also be completed.)

TUBERCULOSIS DISCHARGE CARE PLAN

Patient Name: _____ Submitted by:

D.O.B: ___/___/___ MR#: _____ Phone: _____ Pager:

Payor Source: _____ Facility:

If Pulmonary TB
Dates of three consecutive negative smears ___/___/___, ___/___/___, ___/___/___

Date patient to be discharged: ___/___/

Discharge to: [ ] Home [ ] Shelter [ ] SNF [ ] Jail/Prison [ ] Other

Discharge Address:

Name of Physician who has agreed to assume care: _____ Phone:

Follow-up appointment date: ___/___/___ Time:

Discharge TB Medication Regimen

INH _____ mg
Rifampin _____ mg
Ethambutol _____ mg
Pyrazinamide _____ mg
B6 _____ mg
Other _____

Number of days of Medication Supply
(there must be enough to get patient through follow up provider appt)

Does this patient require Directly Observed Therapy (D.O.T) by the Health Department?

Contact Information/Household Composition

Number of People in Household

Any children age 5 and younger? _____

Any Immunocompromised individuals? _____

FOR TB CONTROL USE ONLY

DHS Review - Problems noted **Discharge Approved**

Action taken before discharge **Yes ____ No**

Reviewed by _____ **(for K. Moser, M.D. TB Controller)** **Date ___/___/**

Date of Review

(SEE REVERSE SIDE FOR INSTRUCTIONS FOR USE)